# Pediatric Intake Form

3 years to 5 years

Child's Legal Name: _____ Today's Date: _____/_____/_____

Address: _____ City: _____ ST:___ Zip: _____

Home Phone: _____ Parent's Cell Phone: _____

Parent's Email Address:_____

What is your preferred method of contact? Home Phone _____ Cell Phone _____ Email _____ All _____

Date of Birth: ____/____/____ Age: ____ Race: _____ Gender: M F Social Security #:_____

Mother's Name: _____ Father's Name: _____

Sibling's Name(s) and ages: _____ _____

Pediatrician: _____ Phone Number: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your child's care at this office? Yes No

How did you hear about our office? (Please circle all that apply) Family (name) _____

Friend (name) _____ Local Event: _____

CHS Website TV Online Newspaper E-mail Other: _____

Please select any of the applicable reasons that you are pursuing chiropractic care for your child:

____ He/she is continuing care from another chiropractor.
____ I recently had my spine checked and see the value in examining my child for subluxations.
____ I'm concerned about his/her health and am looking for answers.
____ He/She has a specific condition that concerns me. Please explain:_____
_____
____ I have been told that chiropractic care will benefit my child, however, I am not sure how it will help.

Is this visit the result of an auto injury? _____ If yes, when was it?_____/_____/_____

Do you have family members with similar health concerns?_____ If yes, who? _____

Has your child seen another doctor for the issue he/she is being seen today? _____

If yes, please provide name of doctor:_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I understand and agree to allow this chiropractic office to use their Protected Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16%. The patient understands and agrees to allow this chiropractic office to use their Protected Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Protected Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Protected Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:
Guardian's Signature Authorizing Care: _____ Date: _____

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## INSURANCE INFORMATION

Insurance company:_____

Policy #:_____ Policy Holder:_____

Type of insurance: Medicare ___ Medicaid ___ Group Health Plan ___ Other _____

Insured's Name: _____ Insured's Social Security #: _____

Insured's Date of Birth: _____ Male:____ Female: ____ Relationship to patient: _____

Insured's Address: _____ City: _____ St:____ Zip: _____

Secondary Insurance (if any):_____

Policy #: _____ Policy Holder: _____

Is the condition we are treating related to an auto accident? Yes _____ No _____

**MEDICARE ONLY**

*All doctors have been instructed to ask the following questions of all Medicare patients.*

1. Do you or your spouse work for a company that provides you with health insurance? Yes___ No___
2. Are you entitled to Medicare because of End Stage Renal Disease? Yes___ No___
3. Is the illness or injury the result of an accident or illness that occurred at work? Yes___ No___
4. Is this illness or injury the result of an accident or other injury? Yes___ No___
5. Has the treatment for this accident or illness been authorized by the Veteran's Administration? Yes__ No__
6. Are you entitled to any benefits under the Federal Black Lung Program? Yes___ No___
7. Do you have a Medicare Medigap Policy? Yes___ No___ Name of Company_____
8. Do you have a Medicare Supplement Policy? (Policy provided by employer you retired from)? Yes___ No___

Chiropractic HEALTH SOLUTIONS
*Your Solution to a Healthy Lifestyle*
Dr. Brenda Hauer

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**PRENATAL HISTORY**

Was the patient adopted?_____ Were there complications during the pregnancy?_____ If yes, explain:

_____

Were ultrasounds performed during pregnancy? _____ If yes, how many?_____

Were medications/drugs/caffeine taken during pregnancy? _____ If yes, please list type and amount:

_____

Were cigarettes or alcohol used during pregnancy? _____ If yes, please list type and amount:

_____

Location of birth: _____ in hospital _____ in birthing center _____ at home

Birth Intervention:

_____ mother induced _____ mother medicated (Pitocin, etc.) _____ forceps _____ vacuum extracted

Were there complications during delivery? _____ If yes, please explain:

_____

Are there genetic disorders/disabilities? _____ If yes, please explain:

_____

**HEALTH HISTORY**

Does child have any known allergies?_____ If yes, to what? _____

Has your child ever taken antibiotics?_____ If yes, what kind and when? _____

List any current medications: _____

List any past medications:_____

Has child ever had any surgeries?_____ If yes, what surgery and when?_____

Has child been diagnosed with cancer or any other illness?_____ If yes, please explain:_____

_____

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*The following questions are designed to help the doctor provide the best possible care for your child.*

Reason for today's visit: _____

Does your child complain of discomfort? Y N If yes, when did this occur? _____
Was onset: Sudden _____ or Gradual _____ Is problem: Constant _____ or Intermittent _____

Has your child ever had this problem before? Y N _____

Has your child previously been treated for this problem? Y N If yes, by whom? _____

Has your child previously had chiropractic care? Y N If yes, previous chiropractor: _____

**HEALTH HISTORY**

Does your child ever complain of back or neck pain? Y N _____

Does your child ever complain of pains in the legs or arms? Y N _____

Does your child ever complain of headaches? Y N _____

Has your child had asthma? Y N _____

Is your child allergic to anything? Y N _____

Are there any smokers in the child's home? _____

Has your child had any earaches? Y N If yes, at what age did child's first earache occur? _____

How frequently does your child have earaches?_____ In which ear do the earaches occur? R L Both

Is your child presently taking any prescribed medication? Y N _____

Please list any other illnesses that have been a concern for your child: _____

_____

Please list any surgeries your child has had: _____

_____

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Do you have any other concerns about your child's health? _____

**TRAUMA**

Has your child had any recent falls or trauma? Y N If yes, describe the trauma and date it occurred:_____

_____

Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades, or similar? Y N _____

Has your child ever fallen down stairs or fallen from a significant height? Y N _____

Has your child ever been in a motor vehicle collision or a near miss? Y N _____

Has your child ever had a bone fracture or joint dislocation? Y N _____

Has your child had any other trauma or injuries? Y N _____

Does your child ever bang his/her head repeatedly against a wall, bed or other object? Y N _____

**NUTRITION**

Do you have any concerns about your child's diet? Y N _____

Does your child have any food allergies? Y N _____

Does your child have any persistent or intermittently occurring skin rashes? Y N _____

Does your child take vitamin supplements? Y N _____

Does your child eliminate stools each day? Y N _____

For how many months was you child breast fed? _____

What does your child usually eat for breakfast?_____ Lunch? _____
Dinner? _____ Snacks? _____

How much cow's milk does your child drink each day? ___ cups. What is your child's favorite food?_____

What types of fast foods does your child like to eat? _____

**All information provided within this document is true and accurate to the best of my knowledge.**

Patient or Guardian Signature: _____ Date: _____/_____/_____